

moment of birth. The human infant is not sufficiently developed to participate in the human condition until the imprinting of language has been achieved.

Nature often eliminates defective members during early development by spontaneous abortion. We now have the knowledge to assist in this process by following our accepted medical policy of eugenic abortion. Surely this is the least we can do to face up to the responsibilities inherent in the coming age.

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Reference

1. Settle T: What it means to be human. In Mohtadi MF (ed): *Man and His Environment*, vol 3 of *Proceedings of the 3rd International Banff Conference on Man and His Environment*, May 15-17, 1978, Pergamon, Toronto, 1980: 3-18

Le Dr Beck édifie un éloquent plaidoyer contre l'avortement eugénique. Il le fonde en définitive sur le droit de l'enfant malformé ou porteur d'une tare génétique de continuer son développement jusqu'à la naissance.

Mais tous les enfants, même normaux, possèdent ce droit, en morale sinon en loi; on s'étonne que la sollicitude de Beck ne s'étende pas jusqu'à ceux-ci. Tout en condamnant la discrimination envers l'enfant malade ou différent, il prône la discrimination envers celui qui n'est ni l'un ni l'autre. En toute logique il faudrait exiger, avant tout avortement provoqué, que tout soit mis en oeuvre pour démontrer la normalité de l'enfant. Pourtant il s'étend avec raison sur les dangers que certains des examens que cela comporte font courir à l'enfant et aussi sur les effets nocifs des manœuvres abortives sur la mère. *Primum non nocere*, nous rappelle-t-il.

Beck veut bien qu'on soit

sélectif envers l'enfant normal. Il prend bien soin d'assurer qu'il approuve l'avortement motivé par les priorités et aspirations de la mère (il ne parle pas de celles du père). À ses yeux, cette fin-ci rend le fœticide permissible, mais non celle qu'il stigmatise: la fin eugénique. Jusqu'où peut-on être entraîné dès qu'on accepte que la fin seule justifie les moyens?

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[The author responds:]

I am surprised that Dr. Welch is startled by my paper. Welch and I have known one another for more years than either of us would care to admit, and he should be familiar with my long-held and frequently expressed opposition to doctors participating in induced abortion for nonmedical reasons.

I wished to avoid discussion of abortion in unplanned and unwanted pregnancies in order to bring some sharpness of focus to my paper. The conclusion that I favour early abortion for trivial reasons is decidedly mistaken. I am steadfastly opposed to physicians taking human life at any level. In a simpler day these concepts of right and wrong were recognized and founded on a strong theologic and philosophic basis. Such activity by physicians would then have been considered akin to murder by the community, by the Canadian criminal code and by the code of ethics of the medical profession.

I cannot accept the opprobrium of presenting "flawed and perverted" facts without responding to Welch's comment that the effect of rubella in pregnancy has been known for a quarter of a century. He knows as well as I that physicians became aware of this link only in the postwar era — to this old man a situation "newly demonstrated."

I agree with Welch that not advising patients about amniocentesis renders physicians culpable in law. This is, as my paper suggests, a highly undesirable but predictable result of genetic abortion. I therefore strongly urge all physicians and the CMA to rescind their approval of these destructive procedures, which have nothing whatsoever to do with the traditional role of medicine.

I deny that in my article I was "carefully ignoring" anything, as Welch avers. The figures I used were the result of carefully conducted research, responsibly reported in the medical literature.

I, too, agonize over the exquisite distress of parents with an increased risk of bearing further children with, for example, Tay-Sachs disease. However, the solution proposed by Welch cannot be identified in any way as therapeutic or medical in the ordinary sense.

Welch may be right that prenatal genetic monitoring is here to stay. I also agree with him that, with advances in such technology, the decisions will become more difficult and not less so. I sincerely hope, however, that we never accept the philosophic position that "there are no right and wrong decisions." To do so would be to disassociate ourselves from the historical, philosophic and moral stance of our profession.

I can assure Dr. Greenberg that for 40 years I have been very actively involved clinically and administratively with those disabled by mental retardation. I have witnessed the anguish experienced by expectant mothers who already have a child with a genetic disorder. Selective abortion does offer reassurance to many anxious expectant mothers, but this anxiety can also be alleviated to a great extent by skilled medical support and counselling. One must seriously question whether the psychologic advantage gained can justify abortion or any of the

complications that may result from the prenatal screening of a "normal" expectant mother.

The practice of selective feticide involves the destruction (one could more accurately say murder) of the fetus to assuage the distressed and anguished response of the mother and father (and society) to the birth of a handicapped child. If this is not a eugenic procedure, then the word has lost all meaning.

It was a pleasure to receive Dr. McCreary's thoughtful reply to my article. There is indeed bright, new promise that we will be able to provide effective treatment for those with Down's syndrome. However, the anticipated birth of such a child does present the mother and her physician with awesome decisions.

I remain unable to find any distinction between selective abortion carried out now — in terms of intent or practice — and the procedures used by German physicians in the 1920s and 1930s.

If Dr. Tuttle cannot differentiate between the thousands of abortions resulting from the emotionally charged situation of unplanned and unwanted pregnancy in this country and the deliberate searching out of handicapped unborn individuals with the intent of carrying out their abortion, then I am unable to carry on a logical argument with him.

I agree with Tuttle that the dilemma so clearly enunciated by Malthus nearly a century ago is relevant to this discussion. To express it in terms of "people pollution" seems to depart from the high view of the dignity of man individually and as a group that has formed the very foundation of our Western civilization. I fully agree with the sentiments expressed by Dr. Thomas Settle. However, Tuttle's use of Settle's definition begs the question under discussion in my paper.

To suggest that our identity

as human beings is established only when "the imprinting of language has been achieved" seems fatuous. We would be best served by accepting that what is conceived by man and woman is human. Surely, the potential for all the attributes of life and existence are resident in the fetus within the receptive maternal womb from the time of conception and implantation.

Dr. de Bellefeuille, like Dr. Welch, has drawn the assumption from my paper that I sanction and condone abortion for noneugenic reasons. Nothing could be further from my own sentiments or from the intended objective of the misleading paragraph. I sincerely apologize to anyone who may have been similarly confused by my inept phraseology.

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Women in medicine: practice patterns and attitudes

As members of the planning committee for the 100th anniversary of the enrolment of the first woman at Dalhousie University Faculty of Medicine we read with interest the article by Dr. A. Paul Williams and colleagues (*Can Med Assoc J* 1990; 143: 194-201) and would like to echo the last sentence: "Therefore, the extent and effects of the progressive increase in the number of women in Canadian medicine should be documented and assessed on an ongoing basis."

We were somewhat surprised that the authors (four men and one woman) didn't realize that women entering practice today have very few role models to assist them in establishing medical practice while fulfilling their bio-

logic role as childbearers. Once these roles have been integrated additional changes may occur in medical practice. There may also be changes if women, with their longer life expectancy than men, choose to remain in practice longer, even if they maintain their current patterns of practice.

Another reason for alterations in medical practice may be that men are now refusing to continue the patterns established in previous generations. We were surprised to read in the article that the sample of men surveyed worked on average only 45 hours per week, which is well below the traditional estimate of 60 to 70 hours.

We sincerely hope that the authors will continue this work and provide regular updates on their data. We suspect that medicine is changing because of many factors, not only the gender ratio described in this article.

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Tennis elbow and computers

We have recently encountered two cases of a syndrome closely resembling tennis elbow that were clearly related to computer keyboarding. One occurred in our chief of service and one in a data entry person. The latter case was quite severe, with pain, swelling and disability necessitating a week off work. Both cases seemed to be related to the use of standard keyboards at nonstandard heights. Both people are relatively light users and experienced this syndrome during occasional heavy use.

A search of the literature yielded one entry in the *Fuku-*